WATSON MARLOW Fluid Technology Solutions

2025 Benefits Guide

This publication contains important information about your employee benefit program.

Please read thoroughly.

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Welcome to Your 2025 Benefits Guide

Plan Year: January 1, 2025 through December 31, 2025

Watson-Marlow is pleased to present your Employee Benefits for 2025. This Benefits Guide will help you to better understand your benefit options and make great decisions regarding your coverage.

The benefit elections you make during Open Enrollment will be effective January 1, 2025 and will last until December 31, 2025. Be sure you plan accordingly! If you don't enroll within your specified time period, you forfeit the opportunity to make any benefit changes until the next plan year, unless you have a qualifying life event. Be sure you make wise decisions. Specific questions can be answered by the insurance Summary Plan Descriptions (SPDs).

What's New in 2025?

- Plan Design Regarding Benefit Plans:
  - Medical coverage will remain with Blue Cross Blue Shield (BCBS). The current HDHP plan will be eliminated and replaced with two new plan options. There are no changes to the PPO.
  - No change to vision.
  - Enhanced high dental plan.
- FSA Account Rollover in 2025. You will forfeit any amount above $660 left in the account.

Who is Eligible

If you are a Watson-Marlow full-time employee (working 30 or more hours per week) you are eligible to enroll in the benefits described in this guide. You and your eligible dependents are eligible for medical, dental, and vision coverage. Eligible dependents generally include your spouse and dependent children until age 26. You will be required to prove your dependents are eligible dependents under the plan.

How to Enroll

The first step to enroll in your benefits is to review this Benefits Guide. Once you make your selections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

When to Enroll

New hires can enroll within 31 days of your hire date. All benefits will begin on your first day of full-time status.

How to Make Changes

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of a spouse, child or other qualified dependent, change in residence due to an employment transfer for you or your spouse, commencement or termination of adoption proceedings, or change in spouse's benefits or employment status. Changes must be made within 31 days of the event.

Helpful Definitions

In-Network—Providers that have contracted with a network to provide covered services at a negotiated rate (i.e.,—hospitals, doctors, pharmacies, durable medical equipment suppliers, etc.)

Out-of-Network—Providers that have not contracted for reimbursement at a negotiated rate.

Copayment—A specified amount of money you pay each time certain covered services are preformed (i.e.,—office visit, prescription, inpatient treatment, etc.)

Coinsurance—A specified percentage share in which you and the plan pay toward the cost of covered services. Usually, you have to meet your deductible before coinsurance kicks in.

Deductible—Each year you must meet a plan year deductible. This means you must pay a certain amount of money towards covered expenses before the coinsurance kicks in. Coinsurance and Benefit Year Deductibles which apply to the Out-of-Network Out-of-Pocket Maximums shall also contribute to the In-Network Out-of-Pocket Maximums.

Out of Pocket Maximum—Once you meet the out of pocket limit (by paying your part of the coinsurance), the plan pays 100% of any further covered medical expenses that you incur for the remainder of the plan year.

BenManage Enrollment Instructions

Instructions

Welcome to the **Employee Self Service for Benefits** screen.

www.spiraxsarcobenefits.com/WM

To get started, click on either **Start Open Enrollment, Start New Employee Enrollment** or **Life Change Event** button on menu below.

As you proceed through the benefit categories (Medical, Dental, etc.), review the provider, pricing and coverage type that best meets your family's needs. Note that there are options to compare plan pricing and features to assist you with your selections.

Once you have decided on a plan, click on the "select" checkbox next to the plan. Note that you do have the option to waive plan coverage and can modify your selections up to final submit on confirm selections tab.

After you have selected your plan, if you have chosen a plan that requires a dependent (e.g. Employee plus Family) you will need to define those dependents. In most cases your dependents have already been added to the options for you. If not, you will want to have your dependent(s) contact, SSN and birthday information available as you complete this section.

NOTE: You must complete the Confirmation Selection tab and submit prior to your selections to be considered for activation.

Call Center Enrollment Instructions

If you would rather speak with a benefit counselor to complete the enrollment process you can reach the BenManage enrollment center from 8 a.m. to 5 p.m. CT, Monday through Friday at **803.573.2350**. The benefit counselors will provide an overview of the benefits being offered to you and answer any benefit related questions that you may have. They will also fully complete the benefit enrollment process on your behalf if you provide them the authorization to do so.

Your information will be forwarded to your HR Department for review and approval. You can always return to view your status of current benefits as needed or prompt a request for change should you experience a "qualified life event" outside of the open enrollment period.

Please contact your HR Department with questions or issues.

Confirm and Submit

Thank you for selecting (or waiving) your new benefit plans. Please take a moment to review the plans and coverage levels. Select the **Previous** option on the menu below to make any changes up to finalization.

Note: If you waive your health and welfare coverage for any benefits, you will not be able to enroll back into the plan(s) until the next Open Enrollment date unless you experience a "qualified life event".

If you are satisfied with your selection, please add/identify your dependents that are to be included on your plan (if applicable). Once you have identified your dependents, you will be able to use the "submit request" option to finalize and submit your selections.

The HR Department will review your submittal and contact you should we have any additional questions. Thank you.

Enrollment Acknowledgment

If you wish to make additional changes, click on **"decline"** and you will return to the option menu.

Click on **"accept"** if you are satisfied with your selections and wish to proceed with the submittal process.

Note that you will not be enrolled in new plans until you complete this selection and acceptance process. Contact your HR Department should you have any questions regarding this process.

True and complete acknowledgment: The answers I have provided throughout this benefit submission are to the best of my knowledge and belief, true, and complete.

I hereby enroll for benefits for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization any time upon written notice unless I have chosen to use pretax deductions.

You can review the status of your benefits at any time by going to **My Account > My Benefits > Review Benefit**.

2025 Health Plan Comparison

	PPO Plan		HDHP 1650		HDHP 2500	
	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network
Schedule of Benefits						
Benefit Period	January 1 through December 31					
Dependent Age Limit	Up to age 26 (coverage goes through the end of the month in which the dependent turns 26)					
Lifetime Maximum	Unlimited					
Annual Deductible						
Employee Only	$1,500	$1,500	$1,650	$4,000	$2,500	$5,000
Employee + Spouse/ Child(ren)/Family	$3,000	$3,000	$3,300	$8,000	$5,000	$10,000
Annual Out-of-Pocket Maximum (Includes Deductible)						
Employee Only	$3,200	$4,600	$3,000	$8,000	$5,000	$10,000
Employee + Spouse/ Child(ren)/Family	$6,400	$9,200	$6,000	$16,000	$10,000	$20,000
Medical Benefits						
Coinsurance	80% after ded	60% after ded	80% after ded	60% after ded	80% after ded	60% after ded
Preventative Care	100% covered		100% covered		100% covered	
Physician Office Visit (PCP)	$25	60% after ded	80% after ded	60% after ded	80% after ded	60% after ded
Specialist Office Visit	$40	60% after ded	80% after ded	60% after ded	80% after ded	60% after ded
Urgent Care Center	$40	60% after ded	80% after ded	60% after ded	80% after ded	60% after ded
Emergency Room Visit	100% of the first $500 of eligible charges then subject to deductible and coinsurance		80% after ded	60% after ded	80% after ded	60% after ded
Inpatient Stay	80% after ded	60% after ded	80% after ded	60% after ded	80% after ded	60% after ded
Outpatient Therapy	80% after ded	60% after ded	80% after ded	60% after ded	80% after ded	60% after ded
Prescription Drug						
Retail Prescription Copay (30-Day Supply)						
Generic	$5	$5, then 40% of remaining cost	80% after ded	In-Network only	80% after ded	In-Network only
Brand	$45	$45, then 40% of remaining cost	80% after ded	In-Network only	80% after ded	In-Network only
Non-Formulary	$75	$75, then 40% of remaining cost	80% after ded	In-Network only	80% after ded	In-Network only
Specialty	$75	Not covered	80% after ded	In-Network only	80% after ded	In-Network only
Mail-Order Prescription Copay (90-Day Supply)						
Generic	$10 copay	Not covered	80% after ded	In-Network only	80% after ded	In-Network only
Formulary	$90	Not covered	80% after ded	In-Network only	80% after ded	In-Network only
Non-Formulary	$150	Not covered	80% after ded	In-Network only	80% after ded	In-Network only
Specialty	Not covered	Not covered	80% after ded	In-Network only	80% after ded	In-Network only

* Visit **www.southcarolinablues.com** for participating providers to make your benefit dollars go further.

Medical Coverage

Blue Cross Blue Shield (BCBS)

Blue Cross Blue Shield is our exclusive medical healthcare provider. You have the choice of three plans. Each option offers you the ability to choose the benefit plan that best meets your benefit and budgetary needs.

It is important to remember that we are all healthcare consumers with the power to make informed decisions about the service we receive. The medical care and prescription drugs that we utilize have direct impact on the cost of the company's health insurance.

You can locate a physician by contacting Member Services or by logging into the BCBS website at **www.southcarolinablues.com**.

Blue CareOnDemand—Powered by MDLIVE

BCBS offers BlueCare on Demand. This service allows you access to a doctor when it's not an emergency, but you need urgent attention. Blue CareOnDemand is there 24/7 to assist with:

- Common Cold
- Flu-Like Symptoms
- Pink Eye
- Strep Throat
- Earache

Use a smartphone, tablet, or personal computer for easy access—no matter where you are! Download the app and create an account today.

Access the updated Blue CareOnDemand through your My Health Toolkit account: **www.southcarolinalues.com**.

Medical Payroll Deductions

Please review the chart below to find your medical plan premium based on your salary range and plan option. If you participate in the wellness program, you will pay a lower rate in 2025:

Non-Tobacco and With Annual Screening

WATSON MARLOW <$75K

PPO Plan	EE Per Pay Cost	Annual EE Cost
Employee Only	$69.88	$1,816.92
Employee + Spouse	$151.88	$3,948.96
Employee + Child(ren)	$132.79	$3,452.64
Employee + Family	$211.08	$5,488.20

HDHP 1650	EE Per Pay Cost	Annual EE Cost
Employee Only	$35.24	$916.32
Employee + Spouse	$90.24	$2,346.12
Employee + Child(ren)	$75.06	$1,951.68
Employee + Family	$111.65	$2,902.92

HDHP 2500	EE Per Pay Cost	Annual EE Cost
Employee Only	$27.77	$721.92
Employee + Spouse	$71.09	$1,848.36
Employee + Child(ren)	$59.21	$1,539.48
Employee + Family	$87.37	$2,271.72

WATSON MARLOW >$75K

PPO Plan	EE Per Pay Cost	Annual EE Cost
Employee Only	$83.94	$2,182.44
Employee + Spouse	$183.48	$4,770.36
Employee + Child(ren)	$159.52	$4,147.56
Employee + Family	$254.12	$6,607.20

HDHP 1650	EE Per Pay Cost	Annual EE Cost
Employee Only	$43.18	$1,122.60
Employee + Spouse	$105.47	$2,742.24
Employee + Child(ren)	$88.58	$2,303.16
Employee + Family	$134.10	$3,486.48

HDHP 2500	EE Per Pay Cost	Annual EE Cost
Employee Only	$33.95	$882.60
Employee + Spouse	$83.10	$2,160.48
Employee + Child(ren)	$69.87	$1,816.72
Employee + Family	$104.94	$2,728.44

Tobacco and Without Annual Screening

WATSON MARLOW <$75K

PPO Plan	EE Per Pay Cost	Annual EE Cost
Employee Only	$83.86	$2,180.28
Employee + Spouse	$182.26	$4,738.68
Employee + Child(ren)	$159.35	$4,143.12
Employee + Family	$253.30	$6,585.84

HDHP 1650	EE Per Pay Cost	Annual EE Cost
Employee Only	$42.29	$1,099.56
Employee + Spouse	$108.28	$2,815.32
Employee + Child(ren)	$90.08	$2,342.04
Employee + Family	$133.98	$3,483.48

HDHP 2500	EE Per Pay Cost	Annual EE Cost
Employee Only	$33.32	$866.28
Employee + Spouse	$85.31	$2,218.08
Employee + Child(ren)	$71.05	$1,847.40
Employee + Family	$104.85	$2,726.04

WATSON MARLOW >$75K

PPO Plan	EE Per Pay Cost	Annual EE Cost
Employee Only	$100.73	$2,619.00
Employee + Spouse	$220.17	$5,724.36
Employee + Child(ren)	$191.42	$4,977.00
Employee + Family	$304.95	$7,928.64

HDHP 1650	EE Per Pay Cost	Annual EE Cost
Employee Only	$51.70	$1,344.24
Employee + Spouse	$126.56	$3,290.64
Employee + Child(ren)	$106.30	$2,763.72
Employee + Family	$160.92	$4,183.80

HDHP 2500	EE Per Pay Cost	Annual EE Cost
Employee Only	$40.74	$1,059.12
Employee + Spouse	$99.71	$2,592.48
Employee + Child(ren)	$83.85	$2,180.04
Employee + Family	$125.93	$3,274.08

BCBS Prescription Coverage

When you elect medical coverage, you are automatically covered under the BCBS Prescription Drug Plan. This coverage allows you to fill your prescriptions at participating retail pharmacies. There are three categories of drugs under the Plan: generic, preferred brand-name, and non-preferred brand-name. The differences between these categories are described below:

- A generic drug is one that meets the same standards as name brand drugs for safety, purity, strength, and effectiveness. Generic drugs are less expensive than name brand drugs.
- A preferred brand-name drug is a name brand drug (patent protected) with no generic equivalent available.
- A non-preferred brand-name drug is a name brand drug (patent expired) with a generic equivalent available.

Participating Pharmacy	Your Cost for up to a 31-day supply on the Core Plan	Your Cost for up to a 31-day supply on the HSA Plan
Generic	$5 copay	Subject to deductible and coinsurance
Preferred Brands	$45 copay	
Non-Preferred Brands	$75 copay	
Out-of-Network	Subject to deductible and coinsurance	

Mail Order Pharmacy	Your Cost for up to a 90-day supply on the Core Plan	Your Cost for up to a 90-day supply on the HSA Plan
Generic	$10 copay	Subject to deductible and coinsurance
Preferred Brands	$90 copay	
Non-Preferred Brands	$150 copay	
Out-of-Network	Subject to deductible and coinsurance	

Under the Prescription Drug Plan, you have the opportunity to lower the amount you pay by choosing a generic drug whenever possible. Be sure to discuss this option with your physician when he or she writes your prescription.

Generic drugs have a long history of safety and effectiveness. Generic manufacturers must demonstrate that the generic drug has the same medical effect as its name brand equivalent by measuring the rate and extent of drug absorption. Because generic drug companies do not have to spend millions of dollars on research and advertising, they can sell the generics for a lot less. These manufacturers compete against each other which keep the generic prices more affordable.

BCBS Mail Order Prescriptions

As a BCBS customer, you'll have access to OptumRx's Mail Service Pharmacy. Please call OptumRx Home Delivery Customer Care at **855.811.2218** or visit My Health Toolkit with any questions.

You'll Enjoy

- Easy refills—up to a 90-day supply means fewer refills
- 24 hour, toll free hotline to speak to registered pharmacists about medication questions
- Convenient Internet and refill-by-phone services to order your refills any time, any day
- Helpful order updates and refill reminders, by e-mail, phone, or text

Getting Started

Members can call OptumRx Home Delivery to enroll in its FastStart service. The representative will contact their doctors for their prescriptions. They'll need their member ID number, the name of their drug, doctor's name and phone number and their shipping address. They will also need to provide a credit card number to pay for their mail-order prescription, along with the expiration date for the card they use.

Prescription Refills

After you get your initial prescription, you may request a refill on the Internet, by phone or by mail. Have your prescription refill form with your prescription number close by when you reorder. For Internet refills, go to My Health Toolkit and click on the link to OptumRx. You may also call OptumRx Customer Care toll free at **855.811.2218** to refill your prescription by phone. If there are no refills available, OptumRx will call your doctor for authorization to refill your prescription(s). If your prescription is out of refills, please allow extra time to process your order.

Automatic Refills

Your medication will be refilled automatically if you sign up for the Optum automatic refill program on its website or by phone. After you receive your first mail-service prescription, go to your MyHealth Toolkit portal or call OptumRx toll free at **855.811.2218**. If you don't sign up for the automatic refill program, you'll need to request your refills each time you're ready for them, either on the OptumRx's website, by phone or by mailing in your refill form to OptumRx.

Identification Card

Your identification card is one of the most important cards you carry. Providers will accept it when you need covered services. It contains information about your coverage that will help with the fast and accurate processing of any claims.

Notes

1. Identification cards feature the name of the policyholder only. Any dependents who have coverage under this policy (for example, a spouse or child) can still use the ID card, even though it only shows the policyholder's name.
2. Alpha Prefix—is the first three characters of the "Member ID," and identifies your group. A group number does not appear on the identification card.
3. If Optum is the PBM (via the National Alliance contract), RXBin, RXGRP, and Plan Code apply across entire population.
4. Copays (if applicable) do not appear on Identification cards.
5. Single members receive one card, family tiers receive four cards and other tiers of coverage receive two. Additional cards can be ordered via My Health Toolkit® or through Customer Service at **800.922.1185**.
6. Call **844.206.0620** to confirm receipt of your card and get insurance updates delivered straight to your mobile device. Calling is not mandatory. Card will be active as of effective date.

Your ID cards will arrive in an envelope.

BCBS—My Health Tool Kit

These BCBS programs and services can help you make the most of your medical plan.

BCBS offers numerous tools to make it easy to manage and track your medical claims, search for in-network providers, and much more! Please review the information below to learn more about BCBS and their online tools!

Access to **SouthCarolinaBlues.com** and My Health Toolkit:

- Learn more about your plan, and the coverage an programs that come with it
- View claim history and account transactions; print claim forms
- Find information and estimate costs for medical procedures and treatments
- Compare hospitals by number of procedures performed, patients' average length of stay and cost

Make South Carolina Blues your personal health place:

Enjoy a simple way to personalize, organize and access your important plan information. Register on My Health Toolkit on **www.SouthCarolinaBlues.com**. Once you do, you can login anytime, anywhere to:

- Find doctors and compare cost and quality ratings
- Review your coverage
- Manage and track claims
- Access temporary ID cards and find out how to order new ones
- Track your account balances and deductibles
- Find health information and resources
- Browse member perks and discounts
- Compare hospital quality

Download the My Health Toolkit App! With the app you can:

- Use your digital ID card wherever, whenever
- Check the status of your claims fast
- See what's covered by your health plan
- Find a local provider who's right for you

BCBS Member Perks

BCBS offers discounts on a variety of products and services to enhance your quality of life. Think of them as special perks just for being Blue! Please note that these services are not covered under your regular health plan benefits. Visit **www.southcarolinablues.com**, and select Member Perks.

Discounts are available on items such as:

- Hearing screenings
- Hair restoration
- Eyewear
- LASIK services
- Weight loss programs
- Allergy relief products
- Massage therapy
- Fitness centers
- Diet and supplement advisers
- Chiropractic services
- And more!

Blue365 Program

Register today at **www.blue365deals.com** to start receiving your discounts!

What it Offers

Deals on products and services to help keep you happy and healthy. The Blue365 program is sponsored by participating Blue companies. Members can receive regular updates on available deals via email.

How it Works

Register free online. Then browse the current deals in these categories: fitness, personal care, healthy eating, financial health, lifestyle, and wellness.

Two Ways to Save

Some deals give you a coupon code that can be applied to a purchase on a vendor's website, or provide a discounted option. Others take you directly to a vendor's website to make a discounted purchase or enroll in a special discount program.

Medical Plan Cost Comparison Examples

Profile 1—Cam, Low Utilizer (Employee-Only Coverage)

Cam is a low utilizer of healthcare. In this example, his care consists of one annual physical, an office visit for an illness, and three prescriptions.

	HDHP 1650	HDHP 2500	Traditional PPO
Deductible to be Satisfied	$1,650	$2,500	$1,500
Out-of-Pocket Max to be Satisfied	$3,000	$5,000	$3,200
Employer Account Funding	$1,000	$1,000	$0
Cam's Services	Cost of Care	Cost of Care	Cost of Care
1 Preventive Physical Exam (Assumes $125 Office Visit Charge)	$0	$0	$0
1 PCP Visits (Assumes $125 Office Visit Charge)	$125	$125	$25
2 Generic Non-Preventive Retail Prescriptions (Assumes $30 Total Cost/30-Day Rx)	$60	$60	$10
1 Brand Non-Preferred Retail Prescriptions (Assumes $200 Total Cost/30-Day Rx)	$200	$200	$75
Totals	Cost of Care	Cost of Care	Cost of Care
Out-of-Pocket Expenses	$385	$385	$110
Expenses Covered by Account Funding	$385	$385	$0
Net Out-of-Pocket	$0	$0	$110
Annual Payroll Contributions (With Wellness <$75K)	$916	$722	$1,817
Annual Payroll Contributions (With Wellness >$75K)	$1,123	$883	$2,182
Annual Payroll Contributions (Without Wellness <$75K)	$1,099	$866	$2,180
Annual Payroll Contributions (Without Wellness <$75K)	$1,344	$1,059	$2,619
Total (With Wellness <$75K)	**$916**	**$722**	**$1,927**
Total (With Wellness >$75K)	**$1,123**	**$883**	**$2,292**
Total (Without Wellness <$75K)	**$1,099**	**$866**	**$2,290**
Total (Without Wellness >$75K)	**$1,344**	**$1,059**	**$2,729**

Profile 2—Steve, High Utilizer (Employee-Only Coverage)

Steve is a high utilizer of healthcare and is managing a complex heart condition. His care consists of regular visits with his primary care physician and cardiologist. He had one surgical procedure and takes medication on an ongoing basis to manage his condition.

	HDHP 1650	HDHP 2500	Traditional PPO
Deductible to be Satisfied	$1,650	$2,500	$1,500
Out-of-Pocket Max to be Satisfied	$3,000	$5,000	$3,200
Employer Account Funding	$1,000	$1,000	$0
Steve's Services	Cost of Care	Cost of Care	Cost of Care
1 Preventive Physical Exam (Assumes $125 Office Visit Charge)	$0	$0	$0
4 Sick Visits With Primary Care Physician (Assumes $125 Office Visit Charge)	$500	$500	$100
1 Inpatient Procedure (Assumes $5,000 Charge)	$1,920	$2,600	$2,120
8 Specialist Visits With Cardiologist (Assumes $350 Per Office Visit Charge)	$560	$560	$320
12 Preferred Brand Retail Prescriptions (Assumes $100 Cost/30-Day Rx)	$20	$240	$540
Totals	Cost of Care	Cost of Care	Cost of Care
Out-of-Pocket Expenses	$3,000	$3,900	$3,080
Expenses Covered by Account Funding	$1,000	$1,000	N/A
Net Out-of-Pocket	$2,000	$2,900	$3,080
Annual Payroll Contributions (With Wellness <$75K)	$916	$722	$1,817
Annual Payroll Contributions (With Wellness >$75K)	$1,123	$883	$2,182
Annual Payroll Contributions (Without Wellness <$75K)	$1,123	$883	$2,182
Annual Payroll Contributions (Without Wellness <$75K)	$1,344	$1,059	$2,619
Total (With Wellness <$75K)	**$2,916**	**$3,622**	**$4,897**
Total (With Wellness >$75K)	**$3,123**	**$3,783**	**$5,262**
Total (Without Wellness <$75K)	**$3,099**	**$3,766**	**$5,260**
Total (Without Wellness >$75K)	**$3,344**	**$3,959**	**$5,699**

Profile 3—Jeff, Highest Utilizer (Employee-Only Coverage)

Jeff is a high utilizer of healthcare and is managing a complex heart condition. His care consists of regular visits with his primary care physician and cardiologist. He had two surgical procedures and takes medication on an ongoing basis to manage his condition.

	HDHP 1650	HDHP 2500	Traditional PPO
Deductible to be Satisfied	$1,650	$2,500	$1,500
Out-of-Pocket Max to be Satisfied	$3,000	$5,000	$3,200
Employer Account Funding	$1,000	$1,000	$0
Steve's Services	Cost of Care	Cost of Care	Cost of Care
1 Preventive Physical Exam (Assumes $125 Office Visit Charge)	$0	$0	$0
8 Sick Visits With Primary Care Physician (Assumes $125 Office Visit Charge)	$1,000	$1,000	$200
Inpatient Procedure (Assumes $5,000 Charge)	$1,520	$2,200	$2,040
12 Specialist Visits With Cardiologist (Assumes $350 Per Office Visit Charge)	$480	$840	$480
Inpatient Procedure (Assumes $4,000)	$0	$800	$430
12 Preferred Brand Retail Prescriptions (Assumes $100 Cost/30-Day Rx)	$0	$160	$0
Totals	Cost of Care	Cost of Care	Cost of Care
Out-of-Pocket Expenses	$3,000	$5,000	$3,200
Expenses Covered by Account Funding	$1,000	$1,000	N/A
Net Out-of-Pocket	$2,000	$4,000	$3,200
Annual Payroll Contributions (With Wellness <$75K)	$916	$722	$1,817
Annual Payroll Contributions (With Wellness >$75K)	$1,123	$883	$2,182
Annual Payroll Contributions (Without Wellness <$75K)	$1,099	$866	$2,180
Annual Payroll Contributions (Without Wellness <$75K)	$1,344	$1,059	$2,619
Total (With Wellness <$75K)	**$2,916**	**$4,722**	**$5,017**
Total (With Wellness >$75K)	**$3,123**	**$4,883**	**$5,382**
Total (Without Wellness <$75K)	**$3,099**	**$4,866**	**$5,380**
Total (Without Wellness >$75K)	**$3,344**	**$5,059**	**$5,819**

Avoid a Scare with Preventive Care

Did you know in-network preventive care is FREE to you if you are covered under one of our health plans? An in-network preventive care visit won't cost you a penny, and it could help you live longer and healthier.

What is Preventive Care?

Preventive care helps evaluate your current health status and can help detect health problems early—before any signs or symptoms have appeared. Through regular preventive exams and screenings, you and your doctor(s) can work together to manage your overall health. Preventive care includes the following:

Wellness checkups are a great way to see your primary care doctor regularly to make sure you are getting the correct health screenings and vaccines based on your age and health status.

Vaccines are needed by kids and adults alike to help prevent illnesses, such as flu and whooping cough.

Screening tests, such as lab work and colonoscopies, can help detect conditions like a diabetes, high cholesterol, or certain kinds of cancer.

Make Sure Your Visit is Free

When you schedule an appointment, make it known you are interested in getting free preventive care only and want to be informed if any services aren't free preventive care.

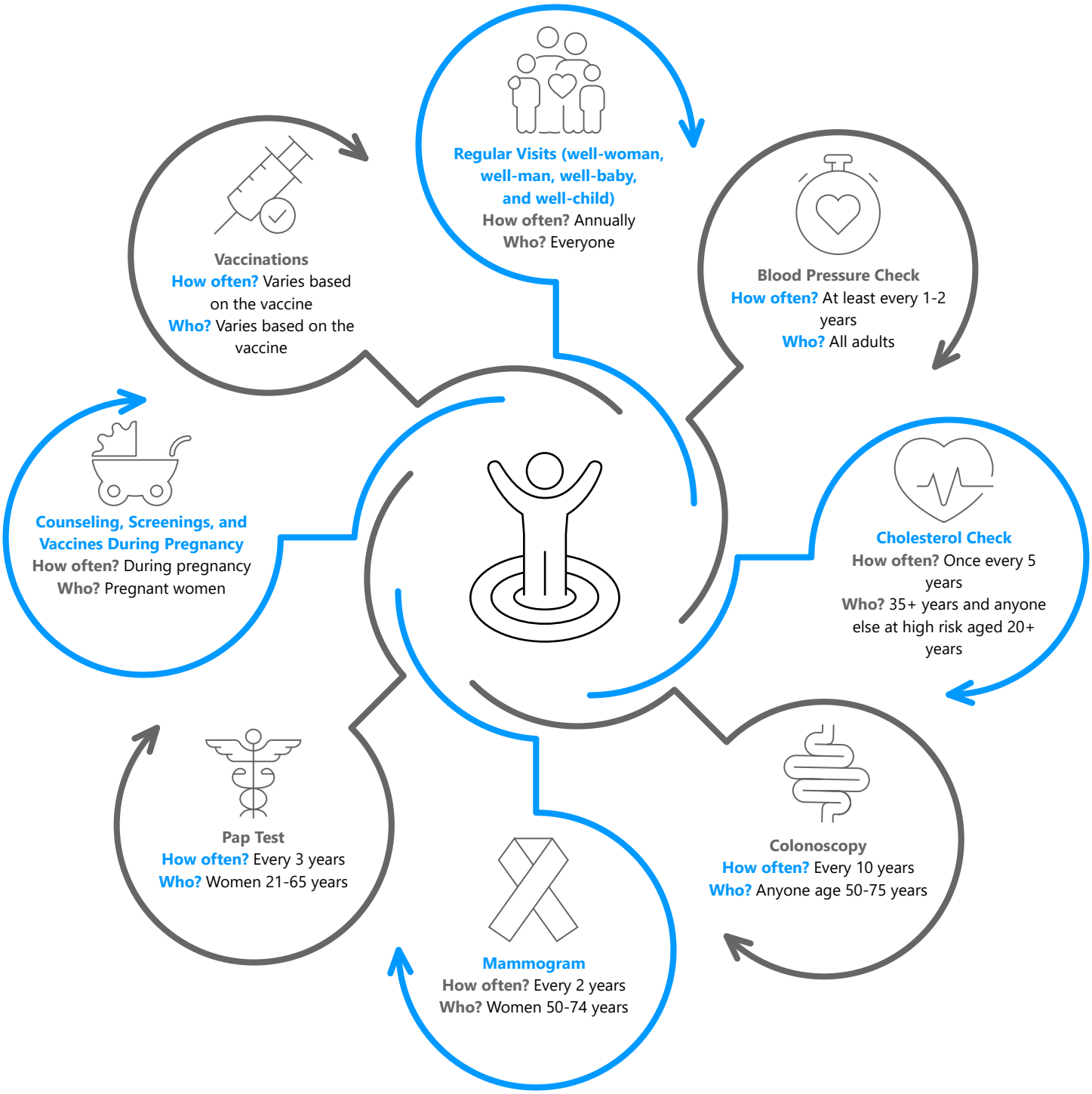
If there is a diagnosis, medical condition, or additional testing/treatment involved in your visit, it will likely not be coded a preventive visit, and you will incur a charge.

Over 100,000 lives could be saved each year if everyone in the United States received the recommended clinical preventive care!*

Don't delay! Call your doctor and schedule your family's preventive care visit today!

* CDC estimate

PREVENTIVE CARE SERVICES



Where Should You Go for Care?

When you find yourself injured or ill, you can save time and money by thinking about the BEST place to get care. Of course, if your condition is life threatening, call an ambulance or go to the ER. If it can wait, take a look at the lists below and consider these tips.

$	**Telehealth** For a minor illness, you might try BlueCare on Demand. It's one of the least expensive options, and it's available 24/7.
$$	**Your Doctor** Your first stop—during business hours—is your regular doctor, if available. Whether you choose a telehealth or in-person visit, your provider knows you and is best equipped to provide personalized care. You'll pay less when you choose an in-network doctor.
$$$	**Retail Clinic** These are a good option for minor illnesses and injuries when your doctor isn't available. They cost a bit less than urgent care centers, but they aren't equipped to stitch you up or take X-rays. Wait times are usually 30 minutes or less.
$$$	**Urgent Care** An urgent care center may be your next step. They can run simple tests, take X-rays, and treat cuts and sprains. They typically get patients in and out in about an hour, and many visits cost around $150.
$$$$	**Emergency Room** The emergency room is always the best place for treating a life-threatening condition. But think twice—or three times—before using it for a minor illness or injury. The cost is a lot higher—usually $1,000 or more—and the wait times are often quite long.

Choose the Right Option for Your Condition

YOUR DOCTOR	TELEHEALTH	URGENT CARE	EMERGENCY ROOM
▶ Checkups and physicals ▶ Common illnesses ▶ Flu shots and other vaccines ▶ Skin conditions ▶ Uncontrolled blood pressure ▶ Health advice ▶ Medication refills or changes ▶ Referrals to specialists ▶ Routine tests ▶ Your regular medical concerns	▶ Back pain ▶ Coughs ▶ Diarrhea ▶ Headache ▶ Heartburn ▶ Red eye ▶ Sinus problems ▶ Urinary problems ▶ Vaginal discharge	▶ Allergic reactions ▶ Animal or insect bites ▶ Acute back pain or injury ▶ Asthma ▶ Bad colds or flu ▶ Cuts requiring stitches (urgent care) ▶ Earaches ▶ Eye infections or irritations ▶ Mild fevers ▶ Minor burns ▶ Nausea, vomiting and diarrhea ▶ Rashes ▶ Sore throats ▶ Sprains or strains ▶ Suspected broken bones (urgent care) ▶ Urinary problems	▶ Suspected broken bones ▶ Coughing or vomiting blood ▶ Chest pain ▶ Difficulty speaking ▶ Head or eye injuries ▶ Dehydration ▶ Poisoning or overdoses ▶ Severe stomach pain ▶ Signs of a stroke: numbing or weakness of limbs, facial drooping, difficulty speaking ▶ Shortness of breath ▶ Urgent lab tests ▶ Loss of consciousness ▶ Uncontrolled bleeding

Meet "Consumerism Connie"

Takeaways: "Know Before You Go" time investment can help achieve higher quality outcome and save money!

Her Story

Consumerism Connie's doctor, Conrad, recommended a hip replacement surgery. Connie's first inclination was to have the procedure done within Dr. Conrad's health system, Centerville City Care Center, that she and the doctor have been part of for decades. But, being the cost-conscious consumer that Connie is (she loves a bargain!), she also wants quality care, and conducts due diligence/research on her proposed procedure.

After logging-in to BCBS's website (**www.southcarolinablues.com**), Connie uses the Care & Cost Finder tool to review alternatives, ratings, and pricing, much like a consumer does. A review of her findings is summarized below.

TOP FOUR "CONSUMERISM" TAKEAWAYS

1. **Choice**—There were four in-network options where Connie could have the procedure done.
2. **Convenience**—All 4 options were only 1.1-3.8 miles away.
3. **Cost**—Total estimated cost ranged from $33.0K-41.4K, although she would hit her OOP maximum regardless.
4. **Quality**—Average star rating ranges from 3.0 to 4.0.

Health Savings Account (HSA)

Flores HSA Mobile App

At Flores, our goal is to help you Own Your Health. Flores Accounts Mobile is all about giving you the tools to take control and better manage your health accounts. Safe and secure, Flores Accounts Mobile offers real-time access for all your account needs, 24 hours a day, seven days a week. It's simple, intuitive, and convenient. For assistance please contact the Client Assistance Center at **800.532.3327**.

Features and Benefits

- Simple and secure login
- Check account balances
- View account activity
- Review and verify IRS-qualified medical expenses
- Make a payment from your account
- File claims with receipt images
- Enter and track expenses
- Easy access to the Client Assistance Center

To Get Started, Follow These Three Simple Steps

- Create your username and password by registering on the HSA website **www.flores247.com**
- Download Flores Account Mobile App
- Log in to Flores Account and start managing your account on the go

Download Flores Mobile today

What are my options at Watson Marlow?

Health Care Spending Account

You can use the tax-free money in your account to reimburse yourself for:

- Eligible expenses not paid by your medical and dental coverage, and
- Out-of-pocket expenses, such as deductibles and co-payments.
- NOTE: If you are enrolled in the HDHP and elect an FSA, you will be enrolled in a limited purpose FSA which can be used to reimburse dental and vision claims only.
- You can find examples of eligible and ineligible expenses in the list below. For a complete list of eligible expenses, you can review IRS Publication 502, which is available from your local Internal Revenue Service Office or by downloading a copy from **www.irs.gov**.

Eligible Expenses	Ineligible Expenses
Deductibles and copayments not paid by other medical, dental or vision insurance	Elective cosmetic surgery, such as liposuction, hair transplants, electrolysis and face-lifts
Hearing aids and batteries	Custodial care in an institution
Contact solutions	Automobile insurance premiums
Smoking cessation aides	Health club dues, YMCA dues, steam baths, etc.

The Health Care Spending Account may be right for you if you and your eligible dependents typically have predictable out-of-pocket medical or dental expenses during the year.

If you choose the Health Savings Account (HSA), the government allows you to set aside pre-tax money into a separate checking account at the bank. You can use the money for your deductibles if you wish or for other items related to Section 125 of the IRS Code, see IRS web-site for full listing.

You can put up to $4,300 (single) or $8,550 (family) for the 2025 plan year.

The contribution amounts are greater than the maximum deductibles. Participants over age 55 have an additional $1,000 catch up provision annually.

Watson Marlow will put money into your HSA account for you if you choose the HSA option.

Watson Marlow will pro-rate HSA employer contributions for new employees based on their benefit eligibility date:

- Example: Single Coverage, benefit eligibility date March 1 = employer contributions of $833.33 upfront ($1,000/12×10 months) for that year.
- Example: Single Coverage, benefit eligibility date July 1 = employer contributions of $500 upfront ($1,000/12×6 months) for that year.

For all current employees enrolling in Medical Coverage for the 2025 Benefit year, Watson Marlow will give you the full HSA Contribution in January 2025.

Total Annual Employer Contribution	
Single	$1,000
Employee & Spouse	$2,000
Employee & Child(ren)	$2,000
Employee & Two or more	$2,000

To be able to contribute to an HSA after age 65, you must not enroll in Medicare. If you are not enrolled in Medicare and are otherwise HSA eligible, you can continue to contribute to an HSA after age 65.

How to Use Your HSA

It's easy to manage your Health Savings Account (HSA) online. Access real-time account balances, transaction history and statements, as well as track your expenses online. Sign up for online banking today.

- **Mobile App—**Use your iOS (iPhone, iPod Touch, iPad) or Android-powered device to check available balances in your account and view HSA transaction details, save and store receipts using your device's camera, receive account balances and configurable alerts via text message, and access customer service contact information.
- **Dashboard—**Use this tool to track your healthcare expenses, submit and retain receipts and claims from multiple insurance and financial account providers. Also view expenses by provider, category, and more.

How to Deposit Funds into your HSA—To maximize HSA tax and savings benefits, begin funding your account as soon as you can. You can even rollover funds from a previous HSA. Flores offers several convenient methods for making contributions to your HSA:

- **Payroll Deductions—**Flores will facilitate recurring pre-tax payroll deductions. Log into your account to update your HSA contribution anytime throughout the year.
- **Online Transfers—**On the Flores website, you can transfer funds from an external bank account, such as a personal checking or savings account, to your HSA.
- **Check—**Mail your personal check and completed Contribution Form to: Flores, PO Box 939, Sheboygan, WI 53082

How to Pay for Healthcare Expenses from your HSA—Whether you want to reimburse yourself for an IRS-Qualified medical expense paid out-of-pocket or you want to pay directly from your HSA, Flores offer multiple options for accessing your funds:

- **Health Benefits Debit Card—**Your HSA funds are loaded onto your Flores MasterCard. Simply swipe your card as credit to pull the funds from your HSA account to pay the provider directly.
- **Pay My Provider—**You can also transfer your HSA funds directly to a provider. Through your HSA portal at **www.flores247.com**, choose the Bill Pay option in the My Accounts dropdown. Select Bill Pay and then Pay Someone Else to send payment once, weekly, or monthly.
- **Online Transfers—**You can transfer your HSA funds into your checking/savings account or send yourself a check. Through your HSA portal at **www.flores247.com**, choose the Bill Pay option in the My Accounts dropdown. Select Bill Pay and then Pay Me to then reimburse yourself via direct deposit or check.

Flexible Spending Account (FSA)

Flores

Flexible Spending Accounts (FSAs) are a tax-free way to pay healthcare, dependent care, and transit expenses that you would typically pay out-of-pocket on an after-tax basis. The money you set aside reduces your taxable income, which can save you money at tax season. You can participate in an FSA even if you are not enrolled in a medical plan.

Flexible Spending Accounts are administered by Flores. They are regulated by the IRS; therefore, certain restrictions and limits apply.

Limited Purpose HCFSA for High Deductible Health Plan Participants

If you are enrolled in a high deductible health plan, whether through Watson Marlow or another group health plan, IRS regulations limit the expenses for which you may be reimbursed under a HCFSA. You may, therefore, only participate in a Limited Purpose HCFSA for dental and vision expenses only. You can still use a Health Savings Account (separate account) to pay for eligible medical expenses and prescriptions.

Download Flores Mobile today

Download on the App Store

GET IT ON Google Play

Healthcare FSA

Healthcare FSAs are used to pay for eligible healthcare expenses such as copays, deductibles, dental, and vision expenses. You will be provided with a debit card you can use to draw money from the account to pay at the doctor's office or pharmacy. The IRS maximum contribution to the Healthcare FSA is $3,300.

Please plan your contributions carefully. Any money remaining in your accounts after the claim submission deadlines will be forfeited. This is known as the "use it or lose it" rule and it is governed by IRS regulations. Note that FSA elections do not automatically continue from year to year; you must actively enroll each year.

Keep in mind, for 2025, you will forfeit any amount above the $660 after the claim submission date of March 31, 2026. Up to $660 may be rolled over to the next plan year if you re-enroll in an FSA.

FSAs and eligible expenses are regulated by the IRS. For a detailed list of eligible expenses, visit **www.irs.gov/publications** and search for Publication 502 or visit the WEX website.

Some examples of eligible healthcare expenses include:

- Office copays
- Prescription drugs
- Dental expenses, including orthodontia
- Vision care expenses, including laser eye surgery
- Chiropractic services
- Acupuncture
- Over-the-counter healthcare products accompanied by a doctor's prescription)

Dependent Care Spending Account

You can deposit up to $5,000 in your Dependent Care Spending Account. This account lets you set aside pre-tax dollars to pay dependent care expenses that are necessary in order for you (and your spouse, if you're married) to work or attend school full-time. You can find examples of eligible and ineligible expenses below. Dependent Care does not carry over.

Dependent care expenses will qualify for reimbursement if you meet these IRS requirements:

Eligible Expenses	Ineligible Expenses
Home or day care for dependent children under age 13.	Expenses for days you are not working.
Payments made to a licensed nursery day care or day care center for preschool children.	Child care services provided by another of your dependent children.
Home or day care for dependents of any age who are mentally or physically disabled and are unable to care for themselves.	Care for dependents who have an annual income of $1.
	Expenses you already claimed as deductions or credits on a federal or state income tax return.

- If you're married, both you and your spouse must be working. Spouses who don't work must be full-time students or incapable of caring for themselves.
- If you're married, the total annual amount you deposit can't be more than the lower of your income or your spouse's income.
- If you're single, your dependent day care expenses must be necessary for you to work. You may change your dependent care contribution during the plan year only if you have a change in family status.

The Dependent Care Spending Account may be right for you if you have day care expenses for an eligible dependent while you are at work.

Examples of How you Can Save

Sample employee makes $2,000 per month. This example shows an employee's net pay per month with and without the FSA:

Employee Paycheck Without the Plan	
Salary	$2,000
Insurance Premium	-$100
Health and Daycare Expenses	-$300
FICA, Federal, and State Taxes	-$500
Net Pay Without the Plan	**$1,100**

Employee Paycheck With the Plan	
Salary	$2,000
Insurance Premium	-$100
Health and Daycare Expenses	-$300
Adjusted Earnings	$1,600
FICA, Federal, and State Taxes	-$400
Net Pay With the Plan	**$1,200**

How to Submit a Claim

Flores

Flores Web Portal

You may scan your claim and upload it to our secure website or complete your claim detail online at **www.flores247.com**.

Flores Mobile Smartphone App

Use your phone's camera to take a picture of your documentation and upload. Download Flores Mobile through Apple Store or Google Play.

Mail Claims

Claims Processing
PO Box 31397
Charlotte, NC 28231

Please keep in mind, certified mail will need to be sent to our physical address at 2013 West Morehead Street, Suite B, Charlotte, NC 28208.

Fax Claims

704.335.0818 or **800.726.9982**

All receipts for reimbursement must include the following:

- Date of Service
- Description of Service
- Out-of-Pocket Cost
- Provider Name
- Patient Name

How to Upload a Claim on www.flores247.com

Step One: Log in to **www.flores247.com** using your Participant ID or Username and password. Tip: Your Participant ID will be on any correspondence you have received from Flores.

Step Two: Click "File a new Health Care or Dependent Care Flexible Spending Account Claim." Hit "Next."

Step Three: If you have completed a hard copy claim form and scanned it into your computer, click "Already Completed" to upload your document. If you have not already completed a claim form, fill in your claim detail and hit "Next."

Step Four: Click "Choose File" and choose the file on your computer that contains your scanned documentation that is required to process your claim. Repeat until all documents are attached. Click "Submit" to finalize your claim.

Tip: Update your email or subscribe to SMS notifications in the Settings tab to receive email or text updates on your claim!

PO Box 31397, Charlotte, NC 28231
800.532.3327
flores247.com

Reimbursement for Orthodontia Expenses

Only proof of payment will be required for future claim submissions. Orthodontia will be reimbursable as you pay it, meaning that the payment can only be reimbursed from the plan year in which the payment was made. If you have any questions about reimbursement for orthodontia, you can call an account manager at **800.532.3327**.

The Difference Between an HSA and FSA

Health Savings Accounts (HSAs) and Healthcare Flexible Spending Accounts (FSAs) are both tax-advantaged accounts available through our benefits program. We created this chart below to illustrate the similarities and differences to help you pick which one is best for you:

	Health Savings Account (HSA)	Healthcare Flexible Spending Account (FSA)
Eligibility Requirements	You must be a full-time employee who works a minimum of 30 hours per week and is enrolled in the HSA plan.	You must be a full-time employee who works a minimum of 30 hours per week and is not enrolled in the HSA plan or any HSA. You do not have to be enrolled in a medical plan to contribute.
Eligible Expenses	Qualifying out-of-pocket healthcare expenses for you and your dependents include deductibles, copays, prescriptions, and glasses/contacts.	
Contribution Limits*	Contribute up to $4,300 for employee only coverage and up to $8,550 for family coverage in 2025. If you are age 55 or older, you may contribute an additional catch-up contribution of $1,000.	You may contribute up to $3,300 on 2025.
Changing Contributions	You can change how much you contribute to the account at any point during the year.	You can only change how much you contribute during annual enrollment or if you experience a Qualifying Life Event.
When Can Expenses be Incurred?	Expenses can be incurred any time after you have established your HSA and have started funding it.	Expenses can be incurred between January 1 and December 31 of the plan year.
Claim Deadlines	You can reimburse yourself any time for past medical expenses as long as the expense was incurred after your HSA was opened and you have funds in your HSA.	You have until March 31 to submit receipts for expenses incurred during the previous plan year.
Rollover	Unused balances roll over into the next year.	Up to $660 of unused funds can be rolled over into the next plan year. **You will forfeit any additional unused funds.**
Connection to Employer	You keep your HSA even if you change jobs or retire.	In most cases, you'll lose your FSA with a job change unless you are eligible for FSA continuation through COBRA.
Effect on Taxes	Contributions are tax-deductible, but can also be taken out of your pay pre-tax. Growth and distributions are tax-free.	Contributions are pre-tax and distributions are untaxed.
How Do I Pay for Expenses?	Use your account debit card to automatically pay for qualified expenses at the point of service. You may also submit claims for reimbursement.	
Usage	Balance can be used during the plan year or anytime in the future, including retirement.	Full balance is available upon start of plan year.
Vendor Information	Flores **800.532.3327** **www.flores247.com**	

Dental

Guardian Insurance

Watson Marlow has a preferred list of dentists with Guardian, see **www.guardianlife.com** to find a local dentist in the Guardian network. If you use these providers you will have "contract protection" that a dentist cannot charge you over reasonable and customary charges. If you do not use the network, the dental plan will continue to pay the scheduled amounts.

- **Diagnostic and Preventive Care** (Core Plan and High Plan) are services that are provided on a routine basis. These include oral exams and cleanings, dental x-rays, fluoride application and sealants for dependent children under the age of 15, space maintainers and basic emergency care of an acute condition.
- **Restorative Services** (Core Plan and High Plan) include medically necessary anesthesia, fillings, endodontic, gum and bone surgeries, simple extractions, biopsies and consultations by a specialist when referred by the attending dentist.
- **Major Restorative Services** (Core Plan and High Plan only) include crowns, bridgework, dental implants, dentures and repair of these items.
- **Orthodontic Services** (High Plan only) include orthodontic appliances (braces), active treatment including banding and subsequent retention treatment.

Dental Benefits	High Plan	Core Plan
Annual Deductible	$0	$0
Coverage A—Diagnostic and Preventive Services	100% of allowable charges	100% of allowable charges
Coverage B—Basic and Restorative Services	100% of allowable charges	100% of allowable charges
Coverage C—Major Dental Services	75% of allowable charges	50% of allowable charges
Coverage D—Orthodontics	50% of allowable charges	NONE
Benefit Maximum:		
Coverage's A, B, & C—EMPLOYEE	$2,000 annually	$2,000 annually
A & B Only		
Coverage's A, B & C—DEPENDENTS	$2,000 annually	$2,000 annually
A&B Only		
Coverage D	$2,000 lifetime maximum	N/A

Cost Per Pay Period

	High Plan	Core Plan
Employee Only	$12.63	$3.35
Employee & Spouse	$24.31	$5.74
Employee & Child(ren)	$21.13	$7.90
Family	$31.50	$11.78

Vision

EyeMed

EYEMEDVISIONCARE.COM—INSIGHT NETWORK

Benefits Highlights	In-Network	Out-of-Network Reimbursement
Eye Exam—Glasses or Contact Lenses—once every 12 months	$10 copay	$50
Lenses - once every 12 months		
Single	$20 copay	$42
Bifocal		$78
Trifocal		$130
Lenses Treatment—Unlimited		
UV Coating	$15	
Tint	$15	
Standard Scratch Resistant Coating	$15	
Standard Polycarbonate (age 26+)	$40	
Standard Anti-Reflective Coating	$45	$36
Standard Progressive	$75	$140
Other Add-Ons and Services	20% off retail price	
Frames—once every 24 months Up to $150 retail value	Covered in full; 20% off balance after $150	$120
Contact Lenses—Medically Necessary—once every 12 months	Covered in Full	$210
Contact Lenses—Conventional Elective— once every 12 months In lieu of lenses—up to $150 retail value	Covered in full;15% off balance over $150	$150

Cost Per Pay Period

Single	$3.10
EE + Spouse	$5.89
EE + Child(ren)	$6.20
Full Family	$9.12

VISION MEMBERSHIP PERKS: PLUS PROVIDERS

This Plus Can Really Add Up

Your Inroads to Extra Benefits

It's the little extras that make life fun—the icing on the cake, the sauce on the steak, and of course, the cash you keep when you visit a PLUS Provider.

Choosing an in-network eye doctor already helps you save on annual exams, frames and other perks. But to save even more, visit a PLUS Provider. Getting more without paying more? Now, that's a benefit.

A Bigger Deal Is a Big Deal

Visit a PLUS Provider and you get access to a supersized set of benefits—for starters, try a $0 exam copay and more to spend on frames.* That's on top of everyday savings and other discounts from your EyeMed vision benefits.

* Frame allowance may vary by plan.

Look for the Plus Provider Mark

See exactly where you can boost your benefits on the Provider Locator at **eyemed.com**. With thousands of PLUS Providers across the country—retail, independent, and online—finding one nearby is a snap.

Simply Show Up and Save

All PLUS Provider perks are built right into your vision benefits—no promo codes, no coupons, no paperwork. Simple, streamlined, and stress-free.

Look for a PLUS Provider at eyemed.com

YOUR PLUS PROVIDER BENEFITS

- $0 exam copay
- Extra cash to spend on frames

After Tax Choices

Guardian

Employer-Sponsored Life And Accidental Death & Dismemberment (AD&D) Insurance

- Employee receives two times your annual compensation* (rounded to the highest $1,000) up to a maximum of $450,000.
- You will be charged per pay period the economic benefit of all life insurance amounts over $50,000 per Section 79 IRC.

Base Spouse And Child(ren) Life Insurance

- Spouse: $20,000 for Life and AD&D Insurance.
- Children—14 days to 26 years (26 if full time student): $5,000.
- Cost per pay period: $2.62
- Log into your **www.spiraxsarcobenefits.com/WM** account to enroll in this benefit.

If a new hire enrolls within their initial enrollment the premium should be deducted the first payday deductions are taken for the employee's enrollment. If they do not enroll for this coverage during their initial enrollment period, then they must be approved by the carrier to bind this coverage (EOI) before deductions are taken.

Additional Employee Life Insurance

- Increments of $10,000.
- Minimum coverage is $10,000 and maximum coverage is $500,000.
- There is a guaranteed acceptance amount of $200,000 which means completion of medical questions is not required if you enroll within your initial enrollment (or subsequent open enrollments).
- This only applies to new coverage or coverage increases.
- Refer to the chart for the life only rates.
- Age based reductions when you are age 65 or older, your life insurance benefits will reduce to:
  - 35% of the life insurance benefit at age 65
  - 50% of the life insurance benefit at age 70
- Log into your **www.spiraxsarcobenefits.com/WM** account to enroll in this benefit.

Age Bands	Life only Rate per $1,000
Under Age 29	$0.06
30-34	$0.08
35-39	$0.10
40-44	$0.14
45-49	$0.21
50-54	$0.37
55-59	$0.63
60-64	$0.97
65-69	$1.86
70 and above	$3.02

Additional Spouse Life Insurance

Guardian

- You can purchase Additional Spouse Life Insurance only if you purchase Additional Employee Life Insurance.
- You can select a minimum of $10,000 to $250,000 in $5,000 increments, not to exceed 100% of employee's amount.
- There is a guaranteed acceptance amount of $50,000 which means completion of medical questions is not required if your spouse enrolls within your initial enrollment (or subsequent open enrollments). This only applies to new coverage or coverage increases.
- Refer to the life only rate chart on page 32. Spouse rate is based off the employee age bracket.
- Log into your www.spiraxsarcobenefits.com/WM account to enroll in this benefit.

Additional Child Life Insurance

Guardian

- You may purchase a flat amount of $10,000 in Life Insurance only per dependent child.
- The cost is the same no matter how many children are to be insured on the plan.
- If you do not enroll for this coverage during your initial enrollment period or subsequent open enrollments, then you and/or your family will be required to answer health questions and be approved by the carrier to bind this coverage (EOI). Watson Marlow, Inc. will not deduct any premiums until you are approved by the carrier in this situation.
- Cost per Pay Period: $.78
- Log into your www.spiraxsarcobenefits.com/WM account to enroll in this benefit.

Business Travel Accident Life Insurance

Cigna

You have $50,000 of business travel accident life insurance.

Salary Continuation—Watson Marlow

Guardian

Full time employees are eligible for salary continuation benefits the first of the month following the month in which they complete a 30-day waiting period. The Company has established a uniform procedure when employees are unable to work due to a non-work related illness or injury. An employee of Watson Marlow who is unable to work due to non-occupational illness or injury may apply to have salary continued in the amount shown below during the first 180 days of such disability, depending on the length of the individual's service with the Company.

Salary continuation replaces a percentage of your income for a short period when you are unable to work due to medical reasons. If you are still unable to work after your salary continuation period ends, LTD coverage will begin after any applicable waiting period, providing long-term income replacement.

Years of Service	Amount of Salary Continued
Less than 30 days	Not eligible
More than 30 days but less than 1 year	Up to 26 weeks at 60%
More than 1 year but less than 5 years	Up to 4 weeks at 100%; balance of 26 weeks at 60%
More than 5 years but less than 10 years	Up to 12 weeks at 100%; balance of 26 weeks at 60%
10 years or more	Up to 26 weeks at 100%

If a new hire enrolls within their initial enrollment the premium should be deducted the first payday deductions are taken for the employee's enrollment. If they do not enroll for this coverage during their initial enrollment period, then they must be approved by the carrier to bind this coverage (EOI) before deductions are taken.

Long Term Disability

Guardian

What is Long Term Disability (LTD)?

Long Term Disability is an insurance policy that protects an employee from loss of income in the event that he or she is unable to work due to illness, injury, or accident for a long period of time.

Why Would I Want LTD Coverage?

Some estimates state that the average employee on LTD coverage misses 2.5 years of work. LTD ensures that an employee will still receive a percentage of their income while they are out of work.

If a new hire enrolls within their initial enrollment, the premium should be deducted the first payday deductions are taken for the employee's enrollment. If they do not enroll for this coverage during their initial enrollment period, then they must be approved by the carrier to bind this coverage (EOI) before deductions are taken.

What am I Offered at Watson Marlow?

CORE PLAN
Benefits Begin
Benefit payments will begin after you have been unable to work for 180 days due to your disability For the first two years of disability, you will receive benefit payments while you are unable to work in your occupation. After two years, you will continue to receive benefits if you cannot work in any occupation based on training, experience and education.
Benefit Amount
Covers **60%** of your current monthly compensation* if you suffer from a disabling accident or illness up to a maximum of $8,500 per month. Both total and partial disability is covered.
Rate
Cost is paid by Watson Marlow.

BUY-UP PLAN
Benefits Begin
Benefit payments will begin after you have been unable to work for 180 days due to your disability. For the first two years of disability, you will receive benefit payments while you are unable to work in your occupation. After two years, you will continue to receive benefits if you cannot work in any occupation based on training, experience and education.
Benefit Amount
Covers **70%** of your current monthly compensation* if you suffer from a disabling accident or illness up to a maximum of $10,000 per month. Both total and partial disability is covered.
Rate
$0.200 of your monthly salary.

Annual compensation means an Employee's annual wage or salary as reported by the Employer for work performed for the Employer as of the date the covered loss occurs. It includes earnings received as commissions, bonuses and overtime pay, but not any other extra compensation. Commissions, bonuses and overtime pay will be averaged for the 12 months just prior to the date the covered loss occurs, or the months employed, if less than 12 months.

Family Medical Leave

Family medical leave is administered by Guardian on behalf of the company. Employee FMLA requests will be approved and administered by Guardian to protect your benefits and ensure that qualified claims are filed.

FMLA provides up to 12 weeks of unpaid, job protected leave to “eligible” employees for certain family and medical reasons. Employees are eligible if they have worked for Watson Marlow for at least one year and for 1,250 hours over the previous 12 months.

Reasons for Leave Under The FMLA

Unpaid leave may be granted for any of the following reasons:

- To care for your child after birth, or placement for adoption or foster care;
- To care for your spouse, son, daughter, or parent who has a serious health condition;
- For a serious health condition that makes you unable to perform your job
- Leave for "Qualifying Exigency"—would cover an employee or an employee's spouse, child or parent, who has received a call to support a qualifying Military operation
- Leave to care for an injured service member: the spouse, child, parent, or "next of kin" (defined as the "nearest blood relative") of a covered service member is entitled to leave, to care for the covered service member

Job Benefits and Protection

- For the duration of FMLA leave, Watson Marlow must maintain your health coverage under any "group health plan" on the same terms as if the employee had continued to work.
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

How Do I Request Leave Under the FMLA?

Contact Guardian by calling **888.889.2953** or log on to **https://g00056068.glicleavepro.com**

- Your information will be verified by a Benefit Specialist who will initiate the family medical leave process and answer any questions you may have.
- You will be notified of the status of your FMLA claim once it has been processed.
- Contact your Supervisor or Human Resources to report your absence according to site time off request guidelines. (See Employee Handbook).

Advance Notice and Medication Certification

You may be required to provide advance leave notice and medical certification. Taking leave may be denied if requirements are not met:

- Generally you must provide 30 days advance notice when the leave is foreseeable.
- Watson Marlow may require medical certification to support a request for leave due to a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness-for-duty report to return to work.

888.889.2953

https://g00056068.glicleavepro.com

Voluntary Accidental Death and Dismemberment Insurance (AD&D)

Guardian

Voluntary Accidental Death and Dismemberment Insurance is available for you alone or for you and your eligible dependents under the Family Plan. If selected, the Plan provides additional worldwide protection 24 hours per day and 365 days per year against losses from covered accidents on or off the job whether on business, on vacation or at home.

Voluntary Accidental Death & Dismemberment (AD&D)

SINGLE PLAN	FAMILY PLAN
Specified increments of $10,000 up to a maximum of $500,000 not to exceed 5 times your (employee) annual compensation*	▶ You can select a minimum of $10,000 to $250,000 in $5,000 increments ▶ Child—$10,000

Annual compensation means an Employee's annual wage or salary as reported by the Employer for work performed for the Employer as of the date the covered loss occurs. It includes earnings received as commissions, bonuses and overtime pay, but not any other extra compensation. Commissions, bonuses and overtime pay will be averaged for the 12 months just prior to the date the covered loss occurs, or the months employed, if less than 12 months.

Log into your **www.spiraxsarcobenefits.com/WM** account to enroll in this benefit.

	Rates per $1,000
Employee	$0.02
Spouse	$0.02
Child(ren)	$0.02

Critical Illness

With Critical Illness Insurance, you also get access to health care support services. You can talk with medical and claims experts about your medical coverage, benefits, diagnosis, and treatment options.

Helps Protect Your Finances From An Illness

When you, your spouse or child is diagnosed with a covered condition, you can receive a cash benefit to help pay unexpected costs not covered by your health plan.

Helps Cover Related Expenses

While health plans may cover direct costs associated with a critical illness, you can use your benefit to help with related expenses like lost income, child care, travel to and from treatment, deductibles and copays.

Pays A Cash Benefit Directly to You

Critical Illness insurance can be used however you want, and it pays in addition to any other coverage you may already have. What's more, all family members on your plan are eligible for a wellness-screening benefit, also paid directly to you once each year per covered person.

Benefits (you can purchase this coverage at a group rate)	
For You	You can choose between **$10,000** and **$30,000** of coverage, in increments of $10,000. No medical questions asked.
For Your Spouse	If you elect coverage for yourself, you can choose between **$10,000** and **$30,000** of coverage, in increments of $10,000. No medical questions asked. Not to exceed 100% of employee coverage amount.
For Your Child(Ren)	If you elect coverage for yourself, your child is automatically covered at no additional cost at 50% of your elected amount.

What's Covered

Once your coverage goes into effect, you can file a claim for covered conditions diagnosed after your insurance plan's effective date. Below is the full list of conditions.

Covered conditions—The plan pays 100% of the benefit amount unless stated otherwise.		
Core conditions	Heart Attack R Stroke R—moderate 50% Stroke R - severe 100% Major Organ Failure (Heart, Liver, Pancreas, Lungs) R Coronary Artery Disease R—10% Coronary Artery	Disease w/Bypass R—50% Pacemaker R—10% Transient Ischemic Attack (TIA) R—10% Pulmonary Embolism R—30% Aneurysm R—10% Kidney Failure R
Cancer conditions	Invasive Cancer R Non-Invasive Cancer R—30% Skin Cancer - $250 BRCA1 or BRCA2	Mutation—30% Bone Marrow Failure R Benign Brain or Spinal Cord Tumor R
Other conditions	Addison's disease 30% Coma Loss of Hearing, Sight or Speech Permanent Paralysis Severe Burns Alzheimer's disease—early Stage 50% Alzheimer's disease—advanced Stage 100% ALS (Lou Gehrig's) Dementia—other causes 100% Huntington's disease 30%	Multiple Sclerosis (MS)—early Stage 50% Multiple Sclerosis (MS)—advanced Stage 100% Myasthenia Gravis 30% Parkinson's disease—early Stage 50% Parkinson's disease—advanced Stage 100% Crohn's disease 30% Epilepsy 10% Lupus 30% Ulcerative Colitis 30%
Childhood conditions applies to dependent children only	Autism Spectrum Disorder Cerebral Palsy Cleft Lip or Cleft Palate Clubfoot Congenital Heart Defect Cystic Fibrosis	Type 1 Diabetes Down Syndrome Hemophilia Multisystem Inflammatory Syndrome (MIS) Muscular Dystrophy Spina Bifida
Wellness screening benefit	Payable to any covered person on your plan one time each year, once you provide proof of an eligible health screening.	Employee $50 Spouse $50 Child $50

R = Recurrence Benefit available

When would I need the Recurrence Benefit?

Sometimes people are diagnosed with the same condition twice. If this happens to you, and 6 consecutive months treatment-free, have passed between the first and second diagnoses, we'll pay you an additional benefit (the amount of which is noted in your Certificate). Only the conditions marked (R) in the table above are eligible for the recurrence benefit. Once a recurrence benefit has been paid, no additional benefit will be paid for that critical illness.

Frequently Asked Questions

Do I need to answer any health questions to enroll?

You do not need to answer any health questions to enroll in Critical Illness Insurance, all policies are guarantee-issue with no health questions. If you do not elect coverage during this open enrollment, you can elect coverage during a qualifying life event or future annual enrollment with no health questions asked.

How do I file a critical illness claim?

If you have a diagnosis after the effective date of coverage, you can file a claim with us by downloading forms from our website. We'll ask that you and your doctor provide information about your medical condition.

How do I get the Wellness Screening Benefit?

You may be paid the benefit when you or a covered family member submit proof of a covered screening each year, like specific blood tests, cancer screenings, cardiac stress tests, immunizations, school sports exams and more (may vary by state). The claim form can also be downloaded from our website.

Can I receive benefits for more than one critical illness?

Yes. If you have two qualifying critical illness diagnoses, you will be paid for both. There is not a waiting period between diagnoses. You can only claim benefits once for each covered condition unless a recurrence benefit is payable.

Contributions are made with post-tax dollars so the benefit amount payable to you is not taxed.

Can I take my insurance with me if I leave my employer?

Depending upon state variations and your employer's plan, you may have an option to continue coverage when your employment terminates. Your employer can advise you about your options.

Rates

Rates are effective as of January 1, 2025. The charts below shows possible coverage amounts and their bi-weekly costs. Find your age bracket (as of the effective date of coverage) to see the cost for the coverage amount you choose.

Critical Illness

EMPLOYEE

Bi-Weekly Employee Amount	<30	30-39	40-49	50-59	60-69	70+
$10,000	$1.89	$3.05	$6.00	$11.86	$20.12	$33.88
$20,000	$3.78	$6.09	$12.00	$23.72	$40.25	$67.75
$30,000	$5.68	$9.14	$18.00	$35.58	$60.37	$101.63

SPOUSE

Bi-Weekly Spouse Amount	<30	30-39	40-49	50-59	60-69	70+
$10,000	$1.89	$3.05	$6.00	$11.86	$20.12	$33.88
$20,000	$3.78	$6.09	$12.00	$23.72	$40.25	$67.75
$30,000	$5.68	$9.14	$18.00	$35.58	$60.37	$101.63

CHILD(REN)

Child(ren) will be offered 50% of the Employee's elected coverage amount automatically at no additional charge.

CRITICAL ILLNESS FAST FACT

Most heart attack victims are middle-aged or older; the risk of a heart attack climbs for men after age 45 and for women after age 55.

Accident Insurance

Injuries occurring off the job can be protected with Guardian Accident Insurance. This plan is designed to pay cash directly to you, the employee. This additional cash support can be used to help pay any out-of-pocket expenses related to the injury. Payments are made tax free, to be used at your direction.

Wellness Benefit: $50 per insured Employee or Covered Dependent per year for completing routine wellness screenings.

Some Covered Benefits	Benefit Amount
Hospital Admission	$1,500
Daily Hospital Confinement (up to 365 days)	$300
Daily ICU Confinement (up to 15 days)	$600
Burns	Up to $12,000
Ambulance (Ground/Air)	$200/$1,000
Torn Knee Cartilage	$500

Accident Plan	Bi-Weekly Rates
Employee	$5.81
Employee + Spouse	$9.65
Employee + Child(ren)	$9.68
Family	$13.51

Example: Broken Ankle	Benefit Amount
Emergency Room with X-Ray	$340
Broken Ankle, Closed Reduction (no surgery)	$2,000
Physical Therapy (10 sessions)	$350
Physician Follow-Up (per visit)	$50
Total Dollars Payable to Employee	**$2,740**

Hospital Indemnity Insurance

Hospital Indemnity insurance with Guardian is designed to provide financial assistance for an event that results in a hospital confinement, to supplement your current coverage. Employees can use the benefit shown below, to meet any out-of-pocket expenses and extra bills that can occur. Benefits are paid directly to you, regardless of the actual cost of treatment. Below is an example of how a trip to the Hospital for childbirth would payout.

Covered Benefits	Benefit Amount
Hospital Admission Benefit (max 2 admissions combined with ICU)	$1,000
ICU Admission Benefit (paid if admitted directly to ICU)	$2,000
Daily Hospital Confinement (up to 30 days per year)	$200
Daily ICU Confinement (up to 30 days per year)	$400

Hospital Indemnity Plan	Bi-Weekly Deduction
Employee	$8.34
Employee + Spouse	$18.07
Employee + Child(ren)	$14.07
Employee + Family	$23.79

Example: Childbirth with a 3 day stay	Benefit Amount
Hospital Admission Benefit	$1,000
Daily Hospital Confinement (starting day 2)	$200
Total Benefit Amount	**$1,400**

Employee Assistance Program

Watson Marlow offers an Employee Assistance Program (EAP) through First Sun EAP so that employees and their qualified family members can have a place to seek counseling and help. Anything you discuss with them is kept confidential.

The first eight (8) wellness visits are at no charge. Five (5) work-life sessions are included at no charge; these sessions can cover topics such as financial management, legal consultation, and elder and child care consultation.

Available Services Include

Counseling Services

- Personal concerns
- Grief and loss
- Trauma issues
- Anger management
- Family conflicts
- Stress management
- Workplace concerns
- Anxiety

Financial Consulting

- Budgeting
- Debt counseling
- Refinancing
- College funds
- Retirement planning/401k

Legal Services

- Domestic/family
- Civil/consumer
- Criminal
- Estate planning
- Real estate
- Legal documents

Adult Care Resources

- Caregiver support
- Community resources
- Financial/legal education

Childcare Resources

- Child development
- Special needs concerns
- School selection
- Tutoring information
- Parent/child concerns
- Day care information
- Summer camp information

Parenting/Adoption Resources

- Parenting skills/support
- Adoption consultation/information

College Consultation Resources:

- Selection of the appropriate school
- Understanding the application and admission process
- Admissions testing questions
- Financial aid websites

Our dedicated professionals are available 24 hours a day, 7 days a week to serve you. Call toll-free to **800.968.8143** or local in SC to **803.376.2668**. You can also visit **www.firstsuneap.com**.

Global Employee Assistance Program (EAP)

The new group-wide EAP is available to every employee and their dependents around the world, in their local language and includes the services below:

- 24-hour counseling
- Legal and financial support
- 6 face-to-face (or virtual) counseling sessions
- Critical incident advice
- Online resources
- Management support

Follow the steps below to access EAP services directly through the website:

Go to **https://www.guidanceresources.com/**

1. Register using the organization Web ID: HealthAssuredEAP
2. Click on the flag or globe icon on the top right corner
3. Choose your country
4. Choose the service you require—you will be provided with a local number to call

Employee Hotline—Safecall

Safecall Is Your Personal 24-Hour Incident Reporting System

As an organization, we are committed to reducing fraud and unethical practices in the workplace and making it a safe and inclusive place to work, a commitment that is underpinned by our internal policies, procedures, and Code of Conduct already available to you. Failure to comply can have serious implications for our business and its reputation. We encourage you to raise any concerns you may have about potentially unethical conduct or illegal activity by:

- Reporting them to your line manager or
- Speaking to a senior manager or
- Calling Safecall

Safecall should be used when you do not wish to communicate directly with someone within the company. Safecall provides an independent, external reporting line where you can raise your concerns and be assured they will be fully addressed.

Each call is treated in complete confidence by trained Safecall staff who will summarize the content of the call and forward a confidential report for review and proper handling. Safecall will not disclose your name to anyone else if you wish to remain anonymous.

Confidential 24/7 Access!

www.safecall.co.uk/reports
866.901.3295

Independent Confidential Reporting Regarding:

- Accounting irregularities
- Theft
- Substance abuse
- Fraud
- Bribery and corruption
- Unethical conduct
- Industrial accidents
- Unfair labor practices
- Harassment
- Discrimination
- Anti-competitive behavior
- Environmental concerns
- Health and safety
- Price fixing
- Mistreatment
- And more!

You can contact Safecall at anytime and ask to speak to someone in your preferred language (over 40 are covered).

Ethics and Compliance Hotline

- Anonymous
- Confidential
- Easy to use
- Fast
- Always accessible
- Free

We're committed to helping you enjoy a safe, healthy, and friendly work environment. Use Safecall to report things that concern you and be heard. Let us know how you feel.

401(k) Retirement

An employee is eligible to participate at the age of 18 after one month of service and the entry date is the 1st of each month. The default deferral is 6% of your regular earnings. All new hires and employees have the option to "opt out" of the 401(k) at any time.

Vesting

Vesting refers to your "ownership" of your account. You are always 100% vested in your contributions (including any rollover/transfer contributions you have made to the Plan), plus any earnings generated on those contributions.

Save More Automatically With Auto Increase

Watson Marlow is ready to help you build your retirement nest egg more quickly with an automatic yearly increase of 1%.

You can opt out of this at point, by logging into Fidelity's NetBenefits at **www.netbenefits.com**.

That's All There Is to It!

The best part is that you'll barely notice a difference in your take-home pay, but you'll see a big difference in the amount you save for retirement over the long run. Of course, you can choose to adjust or stop your contributions at any time.

Consider rolling over prior retirement accounts to Fidelity Investments to streamline your savings and simplify your life.

Summary Plan Description

The above highlights represent only a brief overview of the Plan's features and do not constitute a legally binding document. Please refer to the Summary Plan Description for more information about the specific Plan provisions.

YOUR CONTRIBUTIONS TO THE PLAN

- You may choose to make the following contributions from 1% to 80% of your eligible pay.
  - Before tax contributions.
  - Roth after-tax contributions.
- An IRS dollar limit for 2025 (adjusted annually for inflation) also applies.
- You may elect to make a catch-up contribution, as long as you are age 50 or older by the end of the calendar year.
- Contributions cannot be determined to be catch-up contributions until the participant's regular pre-tax salary deferral contributions exceed an applicable limit under the plan. (These limits could include the 402(g) limit, the 415 limit, plan limits or limits that apply to highly compensated employees as a result of the 401(k) ADP test or plan specific provisions).
- If you have an existing retirement plan account with a prior employer, you may transfer or roll over the account into the plan.
- You may stop your contributions at any time.
- You may increase or decrease the amount of your contributions at any time.

EMPLOYER CONTRIBUTIONS

Watson Marlow is pleased to provide a competitive plan that includes a fixed Company contribution of 5% of your salary to your 401(k) and a matching contribution of 50% of your first 6% of deferred pay (max 3% Company match). This represents the opportunity for a combined total of 8% company contribution and match to your 401(k).

Easy Access to Your Retirement Account

Your plan website is the first step for anything you want to know about your account. Use it to sign in to your account, find information about your retirement plan benefits, and learn more about saving for your future. Once you have signed in, you can review the current status of your account, make changes, and access tools to help you personalize your retirement strategy. From the main menu, scroll over the tabs to the left and select the action you want to take from the drop-down lists.

Check Account Balance

- Balance automatically appears on the Overview page (in the Home menu at the top of the screen).
- For account balance by fund, click "Details."

Review Investment Performance

- To get performance and fee details for all the funds in your plan, in the Review menu, click "Fund and Fee Information."

Change Contribution Amount

- To choose or change your contribution amount and sign up for annual auto increases, in the Manage menu, click "Contributions."

Change Future Investment Allocations (New Contributions)

- To choose or change how new contributions will be invested, in the Manage menu, click "Future Allocations."

Transfer Between Investment Options (Current Assets)

- To transfer balances between individual or groups of funds, in the Manage menu, click "Transfers."
- To change your overall investment mix, in the Manage menu, click "Current Allocations."

Get Loan Details

- To review loan status and get payoff details for current loans (if applicable), in the Review menu, click "Loans."

Review Your Retirement Outlook

- To view your current retirement forecast, in the Are You OnTrack menu, click on "Brighten Your Outlook."
- To update your retirement goals such as desired retirement age and income, in the Are You OnTrack menu, click on "Profile and Goals."

Calculate Hypothetical Retirement Scenarios

- In the Resources Menu, click "Calculators."
- See the impact of changing your contributions.
- Estimate your Social Security income.
- Determine the true cost of taking a loan from your account.

Customer Service

- From the bottom left on any page, select "Help."

www.netbenefits.com

Making Changes to Your Benefits During the Year

The IRS requires elections made during the Annual Enrollment Period to be effective for the upcoming plan year January 1 through December 31. You may not change your benefit election after the annual enrollment period unless you experience a Qualifying Life Event.

You must update the portal within 30 days of your Qualifying Life Event and provide all required documentation. If you fail to update the portal with your Qualifying Life Event and do not provide documentation, you must wait until the next Annual Enrollment period to change your benefit elections.

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Type of Family Status Change	Required Documentation
	(In addition to one of the documents below you must provide the proper proof of spouse or dependent status from the list on the previous page, if applicable.)
Add or Lose Other Coverage Through Another Employer-Sponsored Plan	▶ Copy of employer letter with an effective date and the name of the dependent(s) who gained or lost coverage, or ▶ Copy of insurance letter with an effective date and the name of the dependent(s) who gained/lost coverage, or ▶ Copy of HIPAA Certificate of Creditable Coverage with the effective date and the name of dependent(s) who lost coverage, or ▶ Copy of insurance ID card with the effective date and the name of the dependent(s) who gained coverage
Add or Lose an Eligible Dependent Birth, Adoption, Placement of Adoption or Death of Spouse or Child	▶ Copy of birth certificate showing you as a parent, or ▶ Copy of adoption agreement, or ▶ Copy of court custody or guardianship documents, or ▶ Copy of the portion of the divorce degree showing the dependent, or ▶ Copy of Qualified Medical Court Support Order (QMCSO), or ▶ Copy of death certificate (if applicable)
Qualified Medical Child Support Order (for a dependent child)	▶ Copy of Qualified Medical Child Support Order (QMCSO)
Marriage, Divorce, Legal Separation or Annulment	▶ Copy of the legal documents with effective dates and name of dependent

Holidays, Vacation, and Sick Time

Holidays

Watson-Marlow, Inc. provides paid holidays as part of its comprehensive benefits package to support staff in their effort to balance work and family responsibilities. Please note the following holiday schedule for 2025:

Floating Holidays: As there are only 9 scheduled holidays, there will be one floating holiday that can be taken at any time throughout the year.

Holiday	Date
New Year's Day	Wednesday, January 1, 2025
Martin Luther King Jr. Day	Monday January 20, 2025
Memorial Day	Monday, May 26, 2025
Juneteenth	Thursday, June 19, 2025
Independence Day	Friday, July 4, 2025
Labor Day	Monday, September 1, 2025
Thanksgiving	Thursday, November 27, 2025
Day After Thanksgiving	Friday, November 28, 2025
Christmas Day	Thursday, December 25, 2025
1 Floating Holiday	To be used any time during the year by December 31, 2025

Vacation

All regular full-time employees accrue vacation on a prorate calendar year basis (January-December) as follows:

Completed Years of Continuous Service	Vacation Accrual	Bi-Weekly Accrual
Initial through the end of 4th year	15 days	4.62
Start of 5th year	17 days	5.23
Start of 10th year	20 days	6.15
Start of 15th year	22 days	6.76
Start of 20th year	25 days	7.69

Vacation Accrual and Tier Progression

Employees will accrue vacation time according to the standard accrual schedule unless a contract specifies different terms. In such cases, the vacation accrual will follow the terms of the contract.

As you continue your journey with us, your vacation time will grow with you! Our payroll system automatically updates your vacation accrual based on how long you've been with the company. For example, when you reach 5 years of continuous service, you'll start accruing 17 vacation days a year. Rather than receiving all of your extra days at once, your vacation time will steadily build up throughout the year at the new rate. Please reference the vacation accrual schedule.

New! Watson-Marlow is excited to announce an enhancement to our Vacation Policy. Starting in 2025, you'll be able to roll over up to 40 hours of accrued vacation time into the following year. This means any vacation time you earn in 2025 can be carried over into 2026, giving you more flexibility to use your time off.

For more details regarding the Holiday Schedule, Vacation Policy, and Sick Time please visit the Watson Marlow employee portal at **www.spiraxsarcobenefits.com/WM** and click on Employee Handbook in the top tool bar.

Sick Time

Employees will be provided a lump sum of 80 hours of sick time at the start of each benefit year. Employees may use up to 80 hours of sick time per calendar year. Sick time is pro-rated based on the employee's first date of actual work.

Contact Information

Navigating through insurance options, medical plans and preferred networks can be confusing and overwhelming. Below are some helpful websites to make this process easier for you. The benefit website gives you access 24 hours a day to information about your benefits, from work or from home. It also makes it easy for you to obtain frequently used forms so you can keep your benefits information up to date. Take a minute to explore the website at the following address and see how it can make it easier for you to manage your benefits. Review benefit coverage, forms and Summary Plan Documents (SPDs) at: **http://www.spiraxsarcobenefits.com/WM**.

Please see Jessica Nelson, Benefits Administrator, or email Benefits at **Benefits.us@wmfts.com** if you need any assistance.

MEDICAL AND PRESCRIPTIONS

Blue Cross Blue Shield
800.922.1185
www.southcarolinablues.com

BlueCare on Demand
www.bluecareondemandsc.com/landing.htm

OptumRx Home Delivery
855.811.2218

HEALTH SAVINGS ACCOUNT (HSA)

Flores
800.532.3327
www.flores247.com

FLEXIBLE SPENDING ACCOUNT (FSA)

Flores
800.532.3327
www.flores247.com

DENTAL

Guardian
800.627.4200
www.guardianlife.com

VISION

Eye Med
www.eyemedvisioncare.com

LIFE AND AD&D, LONG TERM DISABILITY

Guardian
800.627.4200
www.guardianlife.com

CRITICAL ILLNESS

Guardian
800.627.4200
www.guardianlife.com

HOSPITAL INDEMNITY

Guardian
800.627.4200
www.guardianlife.com

ACCIDENT

Guardian
800.627.4200
www.guardianlife.com

BUSINESS TRAVEL

Cigna
800.244.6224
www.myCIGNA.com

EAP

First Sun EAP
803.376.2668
www.firstsuneap.com

GLOBAL EAP

ComPsych
https://www.guidanceresources.com/

Register using the organization Web ID: HealthAssuredEAP

401(K)

Fidelity
800.294.4015
www.netbenefits.com

Watson Marlow

HEALTH PLAN NOTICES

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1. Medicare Part D Creditable Coverage Notice
2. HIPAA Comprehensive Notice of Privacy Policy and Procedures
3. Notice of Special Enrollment Rights
4. General COBRA Notice
5. Women's Health and Cancer Rights Notice
6. Michelle's Law Notice
    - This notice is still required when a health plan permits dependent eligibility beyond age 26, but conditions such eligibility on student status. Further, the notice is still necessary if the plan permits coverage for non-child dependents (e.g., grandchildren) that is contingent on student status. The notice must go out whenever certification of student status is requested.
7. ADA Wellness Program Notice
8. Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From Watson Marlow About Your Prescription Drug Coverage and Medicare."

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE FROM WATSON MARLOW ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Watson Marlow and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Watson Marlow has determined that the prescription drug coverage offered by the Watson Marlow Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty
There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. See the Watson Marlow Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the Watson Marlow Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Watson Marlow Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Watson Marlow prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information, or call 978-988-8622. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Watson Marlow changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2025
Name of Entity/Sender:	Jessica Nelson
Contact—Position/Office:	Benefits Administratort
Address:	37 Upton Drive Wilmington, MA 01887
Phone Number:	978-988-2678

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

WATSON MARLOW
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is provided to you on behalf of:

INSERT CLIENT'S WRAP PLAN NAME*

* This notice pertains only to healthcare coverage provided under the plan.

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by Watson Marlow that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**
  - **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.

- **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
- **Health care Operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
  - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as Watson Marlow) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.
  - **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
  - **Required by Law**: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
  - **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
  - **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
  - **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
  - **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
  - **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
  - **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require

your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach
Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint
If you have questions about this notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, *or breach notification process*, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official
The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Jessica Nelson
Benefits Administrator
978-988-2678

Effective Date
The effective date of this notice is: January 1, 2025.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

WATSON MARLOW EMPLOYEE HEALTH CARE PLAN

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *60 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within *60 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Jessica Nelson
Benefits Administrator
978-988-2678

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL COBRA NOTICE

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:
Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If you believe you are eligible for this extension, contact the Plan Administrator.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Jessica Nelson
Benefits Administrator
37 Upton Drive
Wilmington, MA 01887
978-988-2678

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Watson Marlow Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The Watson Marlow Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

Core Plan	In-Network	Out-of-Network
Individual Deductible	$1,500	$1,500
Family Deductible	$3,000	$3,000
Coinsurance	20%	40%
HSA Plan	In-Network	Out-of-Network
Individual Deductible	$2,750	$2,750
Family Deductible	$5,500	$5,500
Coinsurance	0%	20%

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at:

Jessica Nelson

Benefits Adninistrator
978-988-2678

MICHELLE'S LAW NOTICE

(To Accompany Certification of Dependent Student Status)

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or
- The date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
- Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact Meaghan Muscato, Senior Human Resource Generalist, 978-988-8622.

NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS

Watson Marlow Wellness Program is a voluntary wellness program available to All employees and their spouses enrolled in the medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act, as applicable, among others.

Details about the wellness program, including criteria and incentives, can be found in the WM Wellness Pamphlet.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Meaghan Muscato at 978-988-2622 or meaghan.muscato@wmfts.com.

The information from the Biometric Screening and will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as . You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Watson Marlow may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) a doctor in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Jessica Nelson at 978-988-2678 or jessica.nelson@wmfts.com.

This benefit guide is only intended to highlight some of the major benefit provisions of the company plan and should not be relied upon as a complete detailed representation of the plan. Please refer to the plan's summary plan descriptions for further detail. Should this guide differ from the summary plan descriptions, the summary plan descriptions prevail.

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